Glossary of Key Health Care Finance Terms

Gross Charges (Revenue) – Total Patient Revenue generated (price x quantity)

Deductions from Revenue – Amount of gross charges not collected due to

- **uncompensated care – charity and bad debt**
- **contractual allowances – difference between charges and payments for all payers**

Net Patient Service Revenue – total amount of cash collected from gross charges

Other Operating Revenue – Miscellaneous non-patient care related revenue (Cafeteria charges, etc.)

Income From Operations - Total Operating Revenue less Total Operating Expense (operations bottom line)

Non- Operating Revenue - Income from Non- Operating Activities – such as investments, gains/losses on disposal of assets, etc.

Net Income (Excess of Revenue over Expense) - Income from Operations plus Non- Operating Revenue

Days of Cash – Cash and Investments/ Average daily cash expenses

Volume (or statistic) - the unit of measure for a particular department that indicates activity – statistics are used to measure productivity, efficiency and for benchmarking.

Patient Days - Patients in an inpatient bed at Midnight

Medical Group RBRVS RVU's (Resource Based Relative Value Scale Relative Value Units) - A nonmonetary unit of measure that indicates the value of procedures conducted by physicians, midlevel providers and other physician extenders.

Payer Mix - the distribution of payers (Medicare, Medicaid, Commercial, private pay, etc). Payer Mix can be measured by revenue or volume.

Outpatient Adjustment Factor - Total Revenue divided by Inpatient Revenue

Adjusted Admission - indicator of overall activity = Total Hospital Admissions (less nursery) * Outpatient Adjustment Factor

Occupied Beds: Total Patient Days / Number of days in period

Adjusted Occupied Beds: Hospital Total Gross Patient Revenue / Hospital Inpatient Revenue x Occupied beds

FTEs per AOB (Adjust Occupied Bed): Total paid Hospital FTEs / Adjusted Occupied Beds

Explanation of benefits
A notice you receive from your insurance company after receiving medical services. It tells you what was billed, what the insurance company will pay, the amount paid and how much you owe.

HIPAA
The Federal Health Insurance Portability and Accountability Act that sets federal standards for protecting the privacy of your health information.

Itemized bill
Your hospital bill that lists all the services you received and the "gross charge" for each.

Managed Care
An insurance plan that requires patients to use specific hospitals and doctors with which the plan has contracted.

Non-covered charges
Charges for medical services that are not paid by your insurance. You may be expected to pay for these charges.

Out-of-network provider
A hospital or physician that is not part of an insurance plan's approved providers of health care services. There is usually an additional cost you must pay to use out-of-network health care providers.

Out-of-pocket costs
Amounts for medical services that are not paid by your insurance. These can be co-pay, co-insurance, or non-covered charges. You may be expected to pay for these items.

Participating Provider
A hospital or physician that agrees to accept your insurance plan's payment as payment in full once you have paid any co-pay, co-insurance and deductibles.

PPO (Preferred Provider Organization)
An insurance plan that pays for health care services provided by a specific group of hospitals and doctors. Patients are free to make appointments with any health care providers within the network without approval from their primary care physician.

Pre-certification/Pre-authorization/Pre-admission approval
An agreement by your insurance company to pay for the treatment you will receive. Hospitals and physicians require this approval before you receive non-emergency health care services.